MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Dr. S, D.C. PO Box 292762 Lewisville, Texas 75029	MDR Tracking No.: M4-04-3750-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Phoenix Assurance Company of New York Box 42	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: WCMPPWC017831

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/19/02	11/19/02	97139-AC	$44.00	$44.00
01/14/03	01/14/03	97139-AC	$44.00	$44.00
01/28/03	01/28/03	97139-AC	$44.00	$44.00
03/28/03	03/28/03	97139-AC	$44.00	$44.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "The additional information consists of the TWCC-14-Day request letter, a copy of the Request for Reconsideration, Patient Profiles, Patient Referrals, Copies of soap notes for all DOS and any additional EOB's received (If any) for all DOS and copies of redacted EOB's from other carriers showing payment for the code in dispute."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "Per Commission Rule 133.307(i), the Respondent has 14 days from receipt of the additional documentation top provide a response. However, the Commission was closed on December 26, 2003, and did not reopen until December 29, 2003. As Respondent files its response to the Fee Reimbursement dispute on or before December 29, 2003, it is timely. Respondent reserves the right to supplement this response." Carrier's EOBs denied services as, "No MAR."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Commission Rule 133.307(j)(f), the reimbursement for this CPT code would be at a "fair and reasonable" rate.

The requestor submitted product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D). The carrier responded but did not refute the requestor's position.

Therefore, based on this information additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
					Total Left Column:		$0.00
					Total Amount Due:		$176.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $176.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of the Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/27/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____